The Prudent Prescriber

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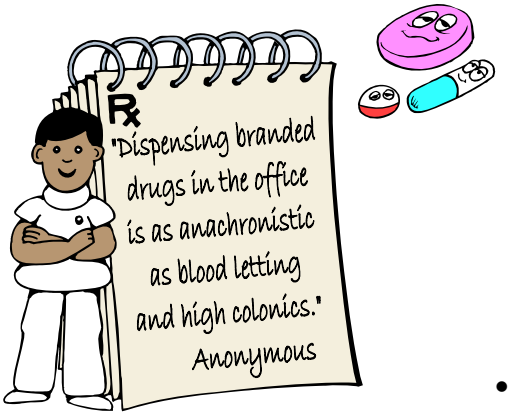

Pharm Reps ≠ Rational Prescribing
(PR) (RP)

JNC 8

JNC 7

- Commissioned by the National Heart, Lung, and Blood Institute (NHLBI) in December, 2003.
- Comprehensive document that covered:
  - Definitions of HTN
  - Issues in BP management
  - Public health perspectives
  - Lifestyle modification
  - Compelling indications for particular drugs
- Recommendations came from RCT evidence, extrapolation of observational data, and expert opinion.

CHF?
Think:
Ace
Aldactone
B-blocker
Dig
Diuretic

Antibiotics do NOT

help acute bronchitis

JNC 8

- The authors were appointed by NHLBI in 2008
- Narrower focus than JNC 7 – on drug treatment
- Recommendations are almost exclusively from large RCT evidence
- Transparent guideline writing process, adherent to the IOM report on creation of trustworthy guidelines
- The authors wrote the guidelines without endorsement from any professional group or society or federal agency.

Avoid these expensive "me-too" drugs:

Intermezzo
Vimovo
Livalo
Pristiq
Viibyrd
Edarbi
Daliresp

ß-blockers in post-MI save lives

"We wanted to make the message very simple for physicians: treat to 150/90 in patients over age 60 and 140/90 for everybody else."
JNC 8 author Dr. Paul James

Pill splitters save BIG

NOW AVAILABLE ON THE GENERIC MARQUEE

Cymbalta→duloxetine
Avapro→irbesartan
Tricor→fenofibrate micronized
Aciphex→rabeprazole
Diovan HCT→valsartan/HCTZ
Atacand HCT→candesartan/HCTZ
Evista→raloxifene

Major deviations from JNC 7

- BP goals
  - 150/90 (over age 60)
  - 140/90 (under age 60)
  - 140/90 (diabetics, CKD, any age)
- Beta blockers no longer recommended as alternative initial therapy

American Society of Hypertension Guidelines

- Published December, 2013; review article format
- Includes some good "front line HTN treatment"
  - Including evaluation, tests, physical examination, drug and non-drug treatment
  - More comprehensive than JNC 8, including mention of therapy choice for compelling indications
    - HTN + DM/CKD = ACEI/ARB
    - Post MI = BB+ACEI/ARB regardless of BP
    - CHF = ACEI/ARB +BB + Diuretic + spironolactone regardless of BP
  - Change BP goal at age 80, not 60 to <150/90

ADA 2014 Standards of Medical Care

- < 140/80 mm Hg - generally
- < 130/80 mm Hg - Younger patients if can be achieved without treatment burden
- Treatment often requires two drugs, one of which should be an ACEI or ARB

	JNC 7	JNC 8	ASH	ADA 2014
SBP	140	150 (60+) 140 (<60)	150 (80+) 140 (<80)	--
DBP	90	90	90	--
Initial therapy	Thiazide	Thiazide ACEI/ARB, CCB	<60: ACEI/ARB >60; CCB, thiazide	--
Diabetics/CKD	130/80	140/90	140/90	140/80
Alternatives	ACEI/ARB, CCB Beta Blocker	-(Beta blockers conspicuously omitted)	--	--
Initial therapy, blacks	Thiazide	Thiazide, CCB (even if diabetic)	CCB, thiazide	--
Diabetics initial therapy	ACEI/ARB for Nephropathy Otherwise Thiazide, ACEI/ ARB, CCB, BB	Thiazide, ACEI/ARB, CCB (if CKD w or w/o DM, use ACEI/ARB)	--	ACEI/ARB

My Take:
Pleasing in their succinctness, transparency and adoption of IOM guideline writing standards, JNC 8 offers: higher target SBP (150) for those over 60 years, add ACEI/ARB and CCB to thiazides as first line drugs, but don't use BB. The new American Society of Hypertension (ASH) guidelines are a more effective tool for in the trenches advice about whom to treat with which drug.

CMS, BZD'S, & Part D Coverage: A Huge Headache for Docs and Patients

CMS, after reading or drinking Beers, decided to reformulate the coverage of benzodiazepines in 2014. Considered high risk medications, health plans are under assault to protect their STAR rating and therein the deluge of letters from their pharmacists to reevaluate your benzo prescriptions. The request is well meaning and in patients' best interests, but onerous. After you have ascertained that it is in your particular patient's best interest to continue the Xanax you prescribed, there are three choices:

1) Request and fill out a Formulary Exception Request form. Be sure to include supporting documentation for your decision making. Health plan pharmacists and/or medical directors will review your request and make a decision.
2) If the benzo you prescribed is not covered by the health plan, consider a "safer" covered alternative or gradually taper and discontinue the drug. A study in the Br. J Gen Pract. 2011; 61:e573-e578 showed that a physician letter to patients taking benzos was effective in decreasing and stopping the drugs. The letter outlined the concerns and risks of continued use and provided a weaning schedule and tips for handling withdrawal. The NNT =12 to effect either reduction or cessation.
3) If you have determined that the benzo is appropriate, counsel your patient to pay out of pocket. Everybody wins! For patients, the cost of the benzo is often less than the copay. For docs, no hassle with the paperwork! For the health plan, CMS finds fewer dangerous drugs and the STARS still shine.

Nasacort – Now OTC

- FDA approved OTC Nasacort Allergy 24 hour (triamcinolone acetonide) on October 11, 2013.
- First nasal steroid approved for nonprescription use.
- Same indication as the prescription product: temporary relief of symptoms of hay fever or other respiratory allergies in adults and children ages 2 years and older.
- The branded and generic will be removed from the market as supplies dwindle.
- OTC Nasacort Allergy 24 hour (120 sprays) $18.99 at Safeway, March 2, 2014. Rx prescription cost is ~$136, generic $80 for 120 sprays.

You may access previous issues at http://www.rmhp.org/providers/prudent-prescriber.